Berjaya Sompo Insurance Berhad (62605-U)

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MEDICAL ATTENDANT'S REPORT ON CRITICAL ILLNESS
(Benign Brain Tumour / Brain Surgery)

This report is to be completed by a registered medical practitioner at the own expense of claimant.	
1. a) Patient's Name b) New IC / Passport No. c) Date of Birth d) Present Occupation	_____ _____ Date :_____ _____
2. a) Please describe the exact details of the patient's condition. b) Date of last visit	_____ _____ _____ Date :_____
3. a) When did the patient first consult you for the condition? b) Symptoms presented at first consultation c) Date of symptoms first appeared prior to first consultation	Date : _____ _____ _____ Date :_____
4. a) Please give full details of the diagnosis b) Date of diagnosis c) Name and address of doctor who established the diagnosis d) Was the patient informed of the diagnosis? If yes, when and by whom?	_____ Date : _____ _____ _____ _____ Yes ☐ Doctor's name : _____ No ☐ Date : _____
5. a) Had the patient suffered any previous episodes of the condition or any other conditions leading to it or relating to it? If yes, please give full details.	Yes ☐ No ☐ Details : _____ _____ _____ _____

6. a) Was the patient referred to you? If yes, please give name and address of doctor concerned.	_____ _____ _____
b) Name and address of doctor(s) who attended to the patient prior to consulting you.	_____ _____ _____
c) Name and address of doctor(s) who is concurrently treating the patient for the condition together with you.	_____ _____ _____
d) Was the patient referred to any other doctor(s) by yourself? Please give name and address of the doctor(s).	_____ _____ _____
7. If the condition was due to an accident, please state:	
a) Date and time of accident.	Date : _____Time_____
b) Full circumstances of accident.	_____ _____ _____
8. a) Please give details of the type of tumour.	Details : _____ _____ _____
b) Exact location of the tumour in the brain.	_____ _____
c) What was the staging of tumour? Please enclose a copy of the CT Scan or MRI report.	_____ _____
d) Was the brain tumour life threatening?	Yes ☐ No ☐
e) Did the brain tumour cause any damage to the brain?	Yes ☐ No ☐
9. Did the patient undergo any surgery / procedure of the brain? If yes, please give details.	Yes ☐ No ☐ Details : _____ _____ _____
a) Date of surgery / procedure.	Date : _____
b) Details of surgery / procedure.	Details : _____ _____
c) Name and address of the surgeon who performed the surgery / procedure on the patient.	_____ _____ _____ _____
10. Had any other investigative tests or procedures been performed? If yes, please give details and enclose a copy of the report.	Yes ☐ No ☐ Details : _____ _____ _____

11. Had the patient been treated for any of the following illnesses? If yes, please provide additional information as per the table below.

	Date of Diagnosis/Onset (dd/mm/yyyy)	Name & address of Doctor(s) consulted	Date of Consultation (dd/mm/yyyy)
a) Hypertension			
b) Diabetes Mellitus			
c) Cardiovascular Disease			
d) Other Illnesses/ Injuries Please specify: i. ii.	 i. ii.	 i. ii.	 i. ii.

12. Please give other information which you feel would be helpful in the assessment of the patient's claim.

_____
_____
_____

Doctor's signature _____ Date : _____

Doctor's name: _____

Doctor's qualification: _____

Clinic's rubber stamp:

Telephone No.: _____